PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at University College Hospital in April 2013, while in the custody of HMP Pentonville

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the investigation report into the death of a man who was found hanging in his cell at HMP Pentonville in April 2013. He was taken to University College Hospital, but died six days later on 20 April 2013. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with the investigation.

The man was first remanded to HMP Thameside on 22 March, and was transferred to Pentonville on 25 March, where he remained until he was found hanging nearly three weeks later. He had a history of poor mental health and suffered from memory loss. He had not been identified as at risk of self-harm or suicide at the prison.

The investigation found that the man had a number of risk factors for suicide and self-harm and had been identified as a risk at court, but it is not clear that these were considered by prison staff who appear to have placed too much reliance on what he told them. The man moved to Pentonville after a very brief stay at Thameside and there was a failure to communicate relevant information between the prisons regarding his alcohol withdrawal prescription and outstanding mental health referral. A mental health referral was subsequently made but the man but was waiting for a full psychiatric assessment when he died.

While it appears that the man gave no clear indication that he intended to harm himself and to that extent it would have been difficult to predict or prevent his death, too little was done to balance known risk factors against personal presentation. I am also concerned that prison staff knew little about the man and there was scant evidence of supportive interaction, a concern expressed in other investigations at Pentonville. Similarly, I am concerned that there was a delay in calling an ambulance when the man was found hanging in his cell – a matter which I have raised previously with Pentonville and about which immediate action was promised.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was remanded to HMP Thameside on 22 March 2013, charged with wounding and affray. He was Sri Lankan and spoke and understood English. He had never been in prison before.

2. When the man arrived at Thameside, he said he had no thoughts of suicide or self-harm. He was not taking any medication. The reception nurse noted that he had an old head injury, and suffered from memory loss as a result. He said he had been assessed by the community mental health services. The man said he drank half a bottle of vodka three to four times a week. Although the GP did not formally assess the man's withdrawal, she prescribed an alcohol detoxification programme.

3. The man appeared in court on 25 March and was then remanded to HMP Pentonville. The man was described as vulnerable on his warrant and it was suggested that he should be placed in the prison healthcare centre because of his mental health problems.

4. When the man arrived at Pentonville, reception staff recorded that he had no thoughts of suicide or self-harm, but had mental health issues. The nurse who completed his health screen noted that he was not currently taking any medication, but had previously stayed in a psychiatric hospital. She recorded that the man needed a "medical/psychiatric report" and assumed this meant his community records would be obtained. No one recorded that the man had been going through clinical detoxification for alcohol withdrawal and there is no evidence that it continued.

5. On 27 March, the mental health team received a psychiatric report about the man, prepared while the man was at court on 22 March. The man was then assessed by a member of the Pentonville mental health team on 28 March. His case was discussed at the mental health team meeting on 2 April when it was agreed that the man showed no signs of having a mental illness but might have an organic brain dysfunction[1]. He was referred for a routine psychiatric assessment, but this did not take place before he died.

6. There were few entries in the man's prison records. On 9 April, he moved from the induction wing to a shared cell on G wing. On 12 April, his cell mate moved to another cell because he was concerned about the man's behaviour. On the morning of 14 April, an officer responded to the man's cell bell three times but he would not speak to her. This happened at least twice more in the afternoon.

7. During the evening roll check at around 8.50pm, an officer found the man hanging from his belt, attached a screw in the wall. He radioed an emergency code and went into the cell. Other officers quickly followed to assist. A nurse arrived within one minute and helped the officers to lower the man to the floor

[1] Organic brain dysfunction refers to a physical disorder causing memory impairment; in this case it was traumatic brain damage.

and they began cardiopulmonary resuscitation (CPR[2]). An ambulance was called at 8.55pm. The man was taken to hospital were he remained in a critical condition until he died on 20 April.

8. There was little recorded interaction between the man and officers during his time at Pentonville. His alcohol detoxification programme ended when he transferred from HMP Thameside, which undermined his continuity of care (although it is unclear whether it was needed). His risk was not assessed effectively in reception, despite a clear warning from court. The man told staff that he had been in a psychiatric hospital, yet his community mental health medical records were not requested until later, and there is no evidence that his GP records were ever requested. Despite his history of mental illness, he was not referred for a mental health assessment at reception. When the man was found hanging in his cell, there was a delay of five minutes before an ambulance was called.

[2] Cardiopulmonary resuscitation (CPR) is a technique where oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Pentonville to inform them of the investigation and asking anyone with relevant information to contact him. One prisoner responded and was interviewed.

10. NHS England appointed a clinical reviewer to review the man's clinical care in custody.

11. HM Coroner for Inner North London District was informed of the investigation and provided a copy of the post-mortem report. A copy of this investigation report has been sent to the Coroner.

12. The investigator visited Pentonville on 26 April 2013 and obtained copies of the man's relevant prison records. On 5 and 25 June 2013, the investigator and the clinical reviewer interviewed eight members of prison and healthcare staff.

13. One of the Ombudsman's family liaison officers, contacted the man's brother and cousin and explained the investigation process. The man's family wrote a detailed account of the man's arrest and said that they believed HMP Pentonville had failed to provide a safe environment.

14. The man's family received a copy of the draft report. They did not make any comments.

HMP PENTONVILLE

15. HMP Pentonville is a local prison serving the courts of North London and holds over 1,300 prisoners.

16. Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust provide health services, including substance misuse, mental health and psychiatric care.

Her Majesty's Inspectorate of Prisons

17. HM Inspectorate of Prisons conducted an unannounced inspection of Pentonville from 24 February to 4 March 2011. The Inspectorate found that not enough support and reassurance was given to prisoners, particularly for those new to custody and foreign nationals. The induction programme was not sufficiently comprehensive and the prison has been repeatedly criticised for how long it took officers to respond to cell bells. The report of a more recent inspection in August and September 2013 has not yet been published.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest annual report, the IMB reported that the mental health team were considerably stretched by the fast turnover of the population, although assessments were carried out efficiently. The Board attributed a 21 per cent increase in the levels of self-harm to better reporting procedures, and considered that there was a heightened awareness of risk among prison staff. The safer custody team was described as diligent in their efforts to create a safe environment, but the Board considered that a significant level of self-harm was inevitable because of the fast turnover of prisoners and the pressures on the regime. The IMB said that the systematic monitoring of the response to emergency cell bells had improved, but the computerised cell bell system was described as far from perfect.

Previous deaths at HMP Pentonville

19. There have been five previous deaths at Pentonville in the past year, three of which were self-inflicted. After a prisoner died in March 2012, we were critical of the lack of staff interaction with prisoners, a criticism we repeat in this investigation.

KEY EVENTS

The man's arrest

20. On Thursday 21 March, the man was arrested and charged with wounding and affray. Although his English was good, police were concerned that the man could not understand why he was in custody and his speech was slurred. He said he had no thoughts of suicide or self-harm and said he did not abuse drugs or alcohol. The police doctor noted that the man suffered from short term memory loss as a result of an old head injury. No other medical concerns were noted.

21. The next day, Friday 22 March, the man was taken to Thames Magistrates' Court. The Person Escort Record[3] (PER) recorded that the man suffered from short term memory loss due to a brain injury. At court, staff were concerned about the man, because he seemed confused and agitated. He was referred to the court's Forensic Mental Health Practitioner for a mental health assessment before his court appearance.

22. The practitioner observed that the man was agitated and appeared uncomfortable (he was bouncing his leg up and down and rubbing his head). His mood was low, his speech was slow and slurred and he looked at times as if he was in pain. The forensic mental health practitioner recorded that the man suffered from possible thought disturbance because he contradicted himself. The man told the forensic mental health practitioner that he had never been diagnosed with a mental health problem, but then he said he was taking medication for depression. The man initially said he had no thoughts of suicide or self-harm, but then said he sometimes did, although did not intend to follow these through. The man said he had been attacked and hit over the head around two years before and attributed his poor memory and concentration to that incident.

23. The man's solicitor told the forensic mental health practitioner that his injuries were from a car accident. The man was registered with Newham Community Mental Health team which informed the forensic mental health practitioner that he had been assessed on 18 March 2013 and was considered to be suffering from thought disturbance. He had a scheduled appointment with the Newham Community Health Mental Health team's psychiatrist on 3 April 2013 for a mental health assessment but he had not been diagnosed with a mental illness. The forensic mental health practitioner noted that he had an alcohol problem, but concluded that his mental health state was unclear, so recommended to the court that he have a psychiatric assessment. She recorded the man's risk of self-harm, suicide and risk to others was not known and said that if he was remanded to prison, she would contact the relevant prison mental health team to ensure he received support.

[3] The Person Escort Record is a form that accompanies prisoners on all journeys to communicate risk factors.

HMP Thameside

24. The court adjourned the man's case and he was remanded to HMP Thameside. When he arrived at the prison the man refused to give his home address, sign the reception personal summary sheet or give details of his next of kin.

25. At an initial health screen on 22 March, the man told a nurse that he did not take drugs, but he drank half a bottle of vodka three to four days a week. He said he had suffered from memory loss since he had been attacked with an axe three years before. The man gave his GP's details and said he was registered with the Newham Community Mental Health team. There is no record that his medical records were requested. The man said he had no thoughts of self-harm or suicide and was not taking any prescribed medication. A nurse recorded that the man had a history of substance misuse and mental health issues but appeared to be fit, well and mentally stable. She referred the man to the mental health team and the prison GP.

26. At 10.25pm a doctor prescribed the man a ten day course of chlordiazepoxide, used to treat alcohol withdrawal, although there was no formal assessment of his alcohol use or level of withdrawal, or any explanation for the prescription. There was no record that the man's blood pressure or pulse was checked. The man's took his last dose of chlordiazepoxide on the morning of Monday 25 March (7.25am) before he left the prison to attend court.

HMP Pentonville

27. The man appeared at Thameside Magistrates' Court on Monday 25 March and the hearing was adjourned to 15 April 2013. He was remanded back to prison and taken to HMP Pentonville. Court officers noted on his remand warrant that the man was vulnerable and should be located in a prison hospital wing because of his mental health problems.

28. In reception, an officer recorded that the man refused to give his home address and his next of kin details. The officer ticked a box on the reception screen to indicate that the man had mental health issues.

29. Another officer explained the prison's rules and procedures to the man. The man told the officer that he had no thoughts of suicide or self-harm. The officer noted that the man had short term memory loss due to a brain injury, but concluded that he was a standard risk and could safely share a cell. The man was then taken to the first night centre, where a nurse completed an initial health screen.

30. The nurse did not have the man's records from court or from HMP Thameside. She did not think she could access the man's records on SystmOne (a prisoner's computerised medical record) because she understood these had to be released by the sending prison. (We understand that this was a common

misunderstanding at that time, which has since been rectified by the software developers.)

31. The man told the nurse that he had sustained a head injury three years ago but he was okay now. He said he had been admitted to a psychiatric hospital in Homerton in 2012. The nurse recorded that the man's mood was depressed, but considered his behaviour and speech were normal and that he had no mental health risks.

32. The man said he had no thoughts of self-harm or suicide. He said he was not taking any prescribed medication and that he smoked and drank four units of alcohol per week. His prescription chart was not scanned on to SystmOne until 3 April, so the nurse did not know that he had been prescribed chlordiazepoxide for alcohol withdrawal. He was not prescribed chlordiazepoxide at Pentonville.

33. The nurse wrote "medical/psychiatric report required – GP". She explained to the investigator that this was a request for his community medical records to be retrieved. She thought that another member of healthcare staff would pick up this entry and request the man's records from his GP and Homerton Hospital. There is no evidence that his records were requested after the health screen.

34. The nurse examined the man and recorded his blood pressure[4] as 110/67 mmHg and his pulse rate[5] at 62 beats per minute. The nurse did not see the remand warrant from court which indicated that the man was vulnerable, had mental health problems and recommended he should be placed in a hospital wing.

35. Every prisoner must be offered a general health assessment within a week of their arrival at the prison. There was no evidence in the man's medical record that this took place.

36. The forensic mental health practitioner was unaware that the man had transferred to Pentonville so faxed her mental health assessment report to HMP Thameside on 25 March, who forwarded it to Pentonville on 27 March. A social worker and a member of the mental health team, reviewed the assessment and noted that the man had been referred to the mental health team because he had presented as confused and agitated at court.

37. The next day, Thursday 28 March, the social worker spoke to the man and described him as pleasant, calm and cooperative and not agitated as he had recently been described at court. The social worker described the man's mood as low but he had no concerns about his behaviour. The man told the social worker that it was his first time in prison and he was unsure what he was charged with. He said he was sleeping and eating well, did not abuse alcohol or take drugs and had no thoughts of self-harm or suicide. The man did not know the day of the week and could not remember his landing or cell number

[4] Blood pressure is considered normal from 90 over 60 (90/60) to 120 over 80 (120/80).
[5] Pulse rate - average resting heart rate for an adult is between 60 and 100 beats per minute

(although at the end of the session the man knew where to go). The social worker recorded that the man was a poor historian because of his head injury.

38. The social worker told the investigator that he had reviewed the man's medical record and assumed that he had completed his alcohol detoxification programme at Thameside because he had not been referred to the detoxification services at Pentonville.

39. The social worker attempted to contact the man's GP after the meeting, but the surgery was closed. There is no record that this was followed up. He contacted Newham Community Mental Health team who agreed to forward medical information about the man. The man's case was scheduled to be reviewed by the prison psychiatrist at the mental health team's multi-disciplinary weekly team meeting.

40. On 31 March, an officer recorded in his case notes that the man's speech was slow due to his head injury. The man told the officer that he had not attended his prison induction programme because he had not been aware of it. The man's name was subsequently added to the induction list.

April 2013

41. On 1 April, an officer unlocked the man's cell for him to attend an induction class. He did not attend the class and no reason was recorded.

42. The man's medical report was received from Newham Community Mental Health team on 2 April. This coincided with the mental health team's multi-disciplinary meeting. The social worker presented his assessment of the man and the Newham report to the psychiatrist forensic consultant psychiatrist, a doctor, and three other nurses. The psychiatrist recorded that the man showed no evidence of having a mental illness but might have an organic brain dysfunction, caused by his head injury. The man was referred to the prison consultant psychiatrist for a routine psychiatric assessment, booked for 17 April 2013. The psychiatrist and the social worker told the investigator that routine appointments would normally be completed within 14 days.

43. On 9 April, the man moved from the induction wing to G wing. Before he moved, an officer recorded that there were no concerns about the man. He told the investigator that he did not specifically remember the man, but he said he would have checked that the man had no outstanding issues and had completed his induction. Although there is no record, an officer said that he thought the man had completed his induction.

44. From 10 April to 12 April, the man shared a cell with another Sri Lankan. He told the investigator that he had known the man for about a year. He said that he had no concerns about him in the community, but he was worried about his demeanour in prison. The man acted as if he was disturbed and would not sleep at night. On one occasion, the man threw his quilt at his cell mate for no reason. His cell mate said the man cried, talked to himself and had

conversations on what appeared to be a pretend telephone when they were locked in their cell. He thought the man was mentally ill.

45. The man's cell mate said that he did not think that the man would harm himself, but he was worried for his own safety, and moved out of the cell on Friday 12 April, at his own request. There is no record of this in either the man's case notes, or those of his cell mate.

46. The investigator reviewed the cell bell report for the man's cell on 14 April, and he pressed the cell bell[6] 11 times. Despite this, there were no concerns recorded in the man's case notes and nothing to indicate why he rang the bell.

14 to 19 April 2013

47. At about 9.00am on Sunday 14 April, an officer unlocked the man's cell. She recalled that he went out during the association period, when prisoners are able to socialise with each other, take showers and make telephone calls. She had no concerns about him. The man's previous cell mate saw him during the association period and was also not worried about him.

48. The officer recorded in the man's case notes that she had responded to his cell bell three times that morning. The officer asked the man if he was okay and whether he needed anything. She said that the man stared at her through the cell door observation panel and did not respond. The officer warned the man not to misuse his cell bell. The officer said she discussed this with two other officers who worked on the wing regularly, but they could not explain the man's behaviour.

49. After prisoners collected their lunch at about 12.00pm, an officer started to lock the cell. He said the man put his foot in the way, when the officer tried to close his cell door. The officer asked if something was wrong but the man just stared at him and did not speak. The officer said that after a short while the man moved his foot and he locked the door.

50. The officer went to the man's cell twice more, in response to his cell bell. He said the man did not speak and stared at him through the observation panel when he tried to talk to him. The officer described the man's stare as threatening.

51. The officer said he went to the man's cell again some time before 5.30pm. (This was likely to have been at 5.03pm according the prison cell bell record.) He said he opened the observation panel and tried to engage the man in conversation but the man just stared at him and did not talk. The officer said he was concerned about the man. As it was a Sunday he telephoned and left a message for the mental health team asking them to see the man the next day. He did not record his concerns on the man's case notes.

[6] Cell bell –all prison cells have a cell bell to for use by the prisoner in an emergency.

52. At about 8.40pm, the officer and Operational Support Grade (OSG) carried out a roll check on G wing. The officer got to the man's cell at 8.50pm. He looked through the cell observation panel and saw the man hanging by a belt, the clip of which was attached to a screw in the wall and the other end tied around the man's neck. (The prison could not explain where the man got the screw.) The officer immediately radioed a level one emergency to indicate a life-threatening situation. He broke his sealed pouch containing a cell key for use in an emergency at night and went into the cell. The OSG said he had heard the alarm on his radio and got to the man's cell seconds later.

53. The officer and the OSG supported the man's body weight to release the tension of the belt on his neck. Three nurses heard the alarm. One of the nurses asked the others to collect and bring the medical emergency equipment and to meet her on G wing. The nurse arrived at the man's cell in less than one minute. The OSG attempted to take the officer's anti-ligature knife from his belt, but before he was able to the nurse passed her anti-ligature knife to the officer, who cut the belt from around the man's neck. (The OSG told the investigator he had not been issued with an anti-ligature knife.) The man was placed on the floor while the nurse examined him. His eyes were open, but he was unconscious. The nurse requested an ambulance (the call was recorded at 8.55pm) and asked the officers to move the man out of the cell where there was more space and it was dry. She started cardiopulmonary resuscitation[7] (CPR) by doing chest compressions just as the other nurses arrived with the emergency medical equipment.

54. The nurse used a defibrillator[8] to assess the man and it advised that CPR should continue. The other nurses assisted with resuscitation, also helped by an officer and a custodial manager who had responded to the emergency.

55. At 9.09pm paramedics arrived at the man's cell and took over CPR. Two more paramedics arrived at 9.13pm. They gave the man cardiac drugs and at 9.20pm and established that the man had a pulse. The paramedics continued to treat the man until he was taken to University College Hospital at 10.05pm accompanied by two prison officers. No restraints were used.

56. The man remained unconscious in a coma, in a critical but stable condition for several days. Healthcare staff at the prison received daily updates from the hospital. On 19 April, the hospital consultant reported that the man was brain dead and he was pronounced dead at 1.15pm on 20 April. The man's family were present when he died.

Support for prisoners

57. Prisoners were informed of the man's death by notices which also outlined the support that was available to them. All prisoners subject to suicide and self-harm prevention procedures were reviewed in case they had been adversely

[7] Cardiopulmonary resuscitation is an emergency procedure which is performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person in cardiac arrest.

[8] A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest

affected by the man's death. The next weekend, prayers were said for the man during the prison church service.

58. The police took away a letter found in the man cell apparently written by him. The letter was not in English and the police said that they would get the letter translated. To date the police have not informed the investigator what the letter said.

Support for staff

59. Immediately after the man was taken to hospital, an operational manager held a hot debrief to support all the staff who had been involved in the incident. The staff care team visited the wing and offered their services for further support.

Family Liaison

60. An officer was appointed as the prison family liaison officer after the man was taken to hospital on 14 April. There were no next of kin details on any of his records and he had not used the prison phone system to telephone anyone. Eventually, on 16 April, the family liaison officer obtained a telephone number for the man's brother from Newham Community Mental Health team. The family liaison officer rang the man's brother in Portsmouth who spoke very little English. He nominated a cousin, who agreed to act as the family's representative and explained that the man's parents lived in Sri Lanka. The man's cousin, who lived in London, met the family liaison officer at the prison around 3.30pm on 16 April and they went to the hospital. The man's brother met the family liaison officer at the hospital later that evening.

61. After the man's death, the prison offered financial assistance towards funeral costs in line with Prison Service guidance. The man's funeral took place on 16 May 2013.

Post-mortem report

62. The post-mortem examination provisionally concluded that the man died of hypoxic brain injury (inadequate supply of oxygen to the brain) caused by hanging

ISSUES

Alcohol detoxification

63. The forensic mental health practitioner who saw the man at court recorded that he had an alcohol problem. During his reception screening at HMP Thameside, the man said that he drank half a bottle of vodka every three or four days but there is no record of an alcohol withdrawal assessment. (There is also other evidence in his records to suggest he did not drink.) Nevertheless, the man was prescribed a 10 day alcohol detoxification medication plan. The only explicit record that he received chlordiazepoxide was a manual prescription chart that was not scanned into SystmOne until 3 April, over a week after he had left Thameside.

64. We agree with the clinical reviewer's view that appropriate alcohol tests would have helped to assess the scale of the man's alcohol problem and that there was no clinical rationale recorded in his medical record to begin an alcohol detoxification programme when he was remanded to HMP Thameside. The failure adequately to record the prescription on SystmOne meant that Pentonville were not aware of his clinical detoxification, and did not continue it. It is not possible to assess the impact of this in the absence of tests, but there is little indication that the man had any symptoms of alcohol withdrawal when he arrived at Pentonville. Nevertheless, continuity of care is important and interruption of such treatment as an early stage could be dangerous. We therefore make the following recommendation:

    The Head of Healthcare at HMP Thameside should ensure that when prisoners are identified as alcohol treatment, full assessments are carried out, and effectively recorded to allow continuity of care.

Transfer of medical records

65. When the man transferred from Thameside to Pentonville on 25 March, his SystmOne medical record would have become automatically available to healthcare staff at Pentonville. Yet the reception nurse was not aware that she could access his records and recorded that the man was not taking any prescribed medication. This was a common mistake that we have identified during our investigation in a different prison. As a result, the software developer has now altered the reception screens to make it easier to access a recently transferred prisoner's SystmOne records. The nurse told the investigator that she can now access a prisoner's SystmOne records as soon as they transfer and we are satisfied that this issue has now been resolved.

Information in reception

66. The reception nurse said that she did not see the man's documents from court and relied on his own account of his medical needs. All relevant records should be made available to the reception nurse to inform the assessment of a prisoner's immediate health needs. It is particularly concerning that the

comments on the remand warrant were not passed to the nurse, as they suggested that the man should be admitted to the prison's hospital wing because of his mental health problems. While an admission to the healthcare centre might not have been necessary this would have prompted an early mental health assessment. We make the following recommendation:

The Governor and Head of Healthcare at HMP Pentonville should ensure that the reception health screen takes into account all relevant available information.

Community medical records

67. The man gave the reception nurse at Thameside his GP's details, and said he had recently been assessed by Newham Community Mental Health team. There is no record that his healthcare records were requested by anyone at Thameside.

68. At his initial health screen at Pentonville, the man told the nurse that he had received psychiatric care at Homerton Hospital within the last twelve months. Although the nurse thought she had asked for his community records to be retrieved, there is no record that the prison contacted Homerton Hospital, or requested the man's GP records after the health screen.

69. The social worker received the court's mental health assessment on 27 March, and contacted Newham Community Mental Health team, who sent through the man's records on 2 April. He tried to contact the man's GP, but there was no answer. There is no evidence that this was followed up, or that the prison ever received the man's GP records.

70. PSO 3050 requires that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he or she has recently been in contact with to inform his clinical care in custody. We make the following recommendation:

The Heads of Healthcare at HMP Thameside and HMP Pentonville should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare.

General health assessment

71. PSO 3050 highlights that a prisoner should be offered a general health assessment in their first week, equivalent to a primary care assessment when registering with a new practice in the community. There is no record that the man received a second health assessment. This was a missed opportunity to assess the man's condition, follow up any missing documentation, discuss his medical history and check how he was settling in. We make the following recommendation:

The Head of Healthcare at HMP Pentonville should ensure a general health assessment is offered to all prisoners in the week after they arrive.

Mental health

72. The man was assessed by a psychiatrist at his first court appearance because court staff were worried about his mental health. Police recorded on his PER that he had a history of mental issues and suffered from memory loss as a result of a previous head injury. The reception nurse at Thameside referred the man for a mental health assessment, but he was transferred to Pentonville before this took place.

73. At his reception screen in Pentonville, he told the nurse that he had been admitted to a psychiatric hospital in Homerton in 2012, and she described him as depressed. Although she said she had limited access to the man's records we would have expected this information to have triggered a referral for a mental health assessment. The changes to SystmOne outlined above should help ensure that referrals are made quickly when they have been identified at other prisons. The nurse concluded that the man was mentally stable and did not refer him for more support or assessment.

74. On 27 March, two days after his arrival at Pentonville, the social worker from the mental health team received the forensic mental health report which indicated a need for a mental health assessment. The social worker concluded there was some cognitive impairment but no evidence of a mental illness. The social worker obtained a report from Newham Community Mental Health team and the man's case was discussed at the mental health team's multi disciplinary meeting on 2 April. The team, which included a psychiatrist, considered that it did not appear the man had a mental illness, but because of the possibility of brain dysfunction booked a comprehensive psychiatric assessment for 17 April.

75. While we would have expected a mental health referral from reception we accept that the need for an assessment was identified quickly afterwards and the man's case was discussed appropriately by mental health professionals who did not identify a need for urgent intervention. When officers identified that the man was behaving strangely on 14 April an appropriate request was made for the mental health team to see him the next day. The clinical reviewer was satisfied that the man's mental health assessments were appropriate to how he presented at the time.

Assessment of risk at Pentonville

76. Reception officers at Pentonville checked the man's remand warrant when he arrived at the prison, on which concerns about the man's vulnerability and mental health had been recorded. A reception officer recorded that the man had mental health problems but he was not identified as at risk of self-harm or considered vulnerable after his reception screening. There is no recorded evidence that the concerns identified at court were considered. The reception nurse did not see the court documents to inform her assessment of the man's level of risk.

77. Prison Service Instruction 64/2011 – Safer Custody, lists a number of risk factors for suicide, including a background history of recent contact with psychiatric services, mental health problems, first time in prison, charged with a violent offence and early days in custody. The man had all of these factors, but there is no record to indicate whether they were taken into account when assessing his risk of suicide and self-harm or what weight was given to them if they were. The records merely reflect that the man said he had no thoughts of suicide or self-harm and that his presentation caused no concerns.

78. Staff judgement is fundamental to assessing risk and relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. Healthcare and prison staff appear to have accepted the man's assurances that he had no thoughts of suicide and self-harm. It is possible that a balanced assessment of the risk might not have led to the man being monitored under suicide and self-harm prevention procedures but there is no evidence this was done. Nor can we know whether identifying the man as a risk of suicide and self-harm would have changed the outcome, but it would have allowed increased monitoring and support. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.

The man's contact with staff

79. During his short time at Pentonville the man was not employed and did not take part in education. As he had no allocated activity he would have spent most of his time locked in his cell with little to do. He did not attend the induction session on the morning of 26 March and no reason was recorded. However, he attended the afternoon session. After five days at Pentonville (31 March), the man told a member of staff that he had not attended his prison induction because he was not aware of it. He then did not attend an induction session on 1 April without explanation. No officer followed this up despite his recorded memory problems. His induction was then recorded as being completed on 9 April and he was moved to a normal residential wing.

80. The last inspection of Pentonville in 2011 found that many unemployed prisoners were locked in their cells for up to 21 hours a day. It does not appear that the man left his cell or the wing very often. The investigator found no one at Pentonville who knew the man well and could explain what he did in the days before his death or how he had seemed.

81. It is not clear from the man's induction paperwork what parts of the induction programme he attended, if any. There are no staff entries about the man's wellbeing until 9 April. This is a concern as it was known that he suffered from memory difficulty. It was his first time in prison and he might have found the early days difficult to understand. He had no personal officer and it is unclear how much interaction staff had with him.

82. Aside from his court hearing, there were no entries in his prison record to indicate any concerns about the man's behaviour even when his cell mate asked to move. Neither are there any concerns noted in the wing observation book.

83. On the day he was found hanging, the man rang his cell bell 11 times. An officer wrote in his case history notes that she responded to three of these cell bells, but did not record her interaction with him. There are no other entries from officers who responded to the man's cell bell that day. Later that afternoon, an officer contacted the mental health team because he was concerned about the man's behaviour, yet there was no corresponding entry in his case notes or the wing observation book to alert other officers to the concerns.

84. The 2011 HM Inspectorate report highlighted that the reception, first night procedures and induction were not sufficiently supportive for new prisoners, particularly those with no previous experience of prison. It added that few personal officers made case notes. This appears still to have been the case when the man was at Pentonville. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

Anti-ligature knives

85. When the man was discovered, the response from staff was swift. Prison Service Instruction 62/2011 states that all uniformed staff must be provided with and carry their own personal issue cut-down tool, an anti-ligature knife. The OSG told the investigator that he had not been issued with one. Although the officer had an anti-ligature knife, in other circumstances, this might have caused delay in cutting a ligature. We make the following recommendation.

The Governor should ensure that all staff carry an anti-ligature knife at all times when on duty.

Ambulance

86. The level one emergency code was called at 8.50pm by an officer. However, it was the nurse who requested an ambulance five minutes later at 8.55pm after arriving at the cell.

87. Prison Service Instruction 3/2013 (issued February 2013) requires that the Governor must have Medical Emergency Response Code protocol in place which ensures that an ambulance is called automatically in a life-threatening medical emergency. Even a short delay in such circumstances can have a significant impact on a person's chance of survival. The PSI has been in force

since 28 February 2013, but Pentonville has not yet introduced the required protocol.

88. An ambulance should have been called as soon as the man was found hanging. We make the following recommendation:

The Governor should ensure in line with PSI 03/2013, that Pentonville has a Medical Emergency Response Code protocol which all staff are aware of and which ensures that ambulances are called automatically as soon as an emergency code is called.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Thameside should ensure that when prisoners are identified as alcohol treatment, full assessments are carried out, and effectively recorded to allow continuity of care.

2. The Governor and Head of Healthcare at HMP Pentonville should ensure that the reception health screen takes into account all relevant available information.

3. The Heads of Healthcare at HMP Thameside and HMP Pentonville should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare.

4. The Head of Healthcare at HMP Pentonville should ensure a general health assessment is offered to all prisoners in the week after they arrive.

5. The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.

6. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

7. The Governor should ensure that all staff carry an anti-ligature knife at all times when on duty.

8. The Governor should ensure in line with PSI 03/2013, that Pentonville has a Medical Emergency Response Code protocol which all staff are aware of and which ensures that ambulances are called automatically as soon as an emergency code is called.

ACTION PLAN: Mr Mahatharan Satheeshkumar on 20 April 2013 - HMP Pentonville

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare at HMP Thameside should ensure that when prisoners are identified as alcohol treatment, full assessments are carried out, and effectively recorded to allow continuity of care.	Accepted	**HMP Thameside** Prisoners who are identified through the reception process as requiring immediate support from alcohol misuse are seen by a GP and placed on a Librium detox. Currently the alcohol detox regime prescribing is put on paper records – The desired regime must be clearly documented on the prisoners S1 notes so that any prison receiving a prisoner, who may be mid way through a detox, is able to see from the S1 notes that a prisoner was currently under treatment.	Completed	
2	The Governor and Head of Healthcare at HMP Pentonville should ensure that the reception health screen takes into account all relevant available information.	Accepted	**HMP Pentonville** The template used for a Reception Screening has been reviewed to ensure a robust clinical risk assessment is completed on arrival in reception. It is now normal practice that the Reception screening nurse has sight of a prisoner's core record and its contents. A clinical review of nursing staff skill mix has also taken place to increase the evening nursing capacity to include mental health nurses.	Completed	
3	The Heads of Healthcare at HMP Thameside and HMP Pentonville should ensure that	Accepted	**HMP Thameside** Every effort is made to make contact with a prisoner GP or CMHT when health concerns have been identified	Completed	

	community GP records and other relevant records are routinely requested to ensure continuity of healthcare.		through the reception process. **HMP Pentonville** A Healthcare Protocol is in place to ensure medical recorders are requested for all prisoners. This is auditable and part of SystemOne (automatic initiation of request). This has also been communicated to Head of Healthcare at HMP Thamesside. It was agreed at NHSE Head of Healthcare quarterly meeting for Greater London that all prisons would request all clinical records for prisoners coming into their care.		
4	The Head of Healthcare at HMP Pentonville should ensure a general health assessment is offered to all prisoners in the week after they arrive.	Accepted	**HMP Pentonville** All prisoners will have a 'Wellman Health Screen' within 48 hours of arriving and Pentonville (new or transfer). If a prisoner does not attend it creates a 'flag' on the system and healthcare will actively see the prisoner.	Completed	
5	The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.	Accepted	**HMP Pentonville** First night risk assessment is completed by Prison staff and screening medical staff with inforamtion/ documentation that is available to them. A large part of the screening process is via prisoner's self-disclosure. Staff including healthcare staff should be trained in ACCT processes along with FNC process.	January 2013	
6	The Governor should ensure that officers have meaningful	Accepted	**HMP Pentonville** We have been running a successful Personal Officer	Completed	

	contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.		scheme. **HIPPO** (Help and Information for Pentonville's Personal Officers) has been recognised Nationally as a great initiative and we consider this the first stage of developing the Personal Officer Scheme. Personal Officer Packs have since been published and handed out to prisoners as an additional tool to aid them and for staff to support them. Management checks are also in place to ensure meaningful entries are made on PNOMIS.		
7	The Governor should ensure that all staff carry an anti-ligature knife at all times when on duty.	Accepted	**HMP Pentonville** Under PSI 64/2010 this is a mandatory requirement for Operational Staff. A notice to staff has been published (October 2013) to remind staff that this is a mandatory requirement. Spot checks by Safer Custody Team are done on a regular basis.	Completed	
8	The Governor should ensure in line with PSI 03/2013, that Pentonville has a Medical Emergency Response Code protocol which all staff are aware of and which ensures that ambulances are called automatically as soon as an emergency code is called.	Accepted	**HMP Pentonville** The new PSI is yet to be implemented but has been drafted and will be finalised between healthcare and HMPS. Protocol to then be published to staff.	3 months January 2014	